Gastroenterology Associates of S.W. Florida, P.A.

Appointment No Show/Cancellation Policy

Patient's Name:____ Date of Birth:_______________

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment no show/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

No Show Policy:

A "No Show" is also considered a "missed appointment" this occurs when you fail to show up for an appointment without a phone call 24 hours prior or you cancel without at least 24 hour notice.

Failure to report at the time of a scheduled appointment will be recorded in your chart as a "No Show". Three (3) "No Show" appointments in a 12-month period, will result in discharge from our practice. A certified letter will be sent to you from your physician withdrawing you from further patient care services.

For each "No Show" there will be $25.00 fee; which will need to be paid in full prior to scheduling any future appointments.

Cancellation Policy:

In order to be respectful of the medical needs of other patients, please be courteous and notify us promptly if you are unable to attend an appointment. This time will be reallocated to someone who is need of treatment. If it is necessary to cancel your scheduled appointment, we require at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

If you cancel your appointment on the same day or less than 24 hour notice it will be considered as a "No Show" (see policy above).

How to cancel appointments in advance?

During normal business hours you may call (239) 275-8882 / (239) 458-0822 Or you may send a secure message any time of day through our secure patient portal (https://giaswfl.portalforpatients.com)

Discharge From Practice

Patients who habitually abuse this policy or who continuously reschedule appointments will be subject to discharge from the practice.

By signing this policy I indicate that I have read and understand the appointment "No Show /Cancellation" policy. I further understand that I will be responsible for any fees assessed to my account for each "No Show" and may be declined future appointments until I have paid in full the outstanding fees.

____ _______________________________

PRINT-Patient Name **Enter Today's Date**

____ _______________________________

Patient Signature or Legal Guardian Signature **Relationship to Patient /and/ Account #**

Gastroenterology Associates of S.W. Florida, PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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